DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 02/13/2008

FORM APPROVED

		& MEDICAID SERVICES			OMB NO). <u>0938-039</u>
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILT	LTIPLE CONSTRUCTION DING	(X3) DATE S	
	•		B. WING			C
		09G119	D. Wilde		01/1	16/2008
NAME OF F	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE	į	
				WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETION DATE
W 000	INITIAL COMMEN	ទេ	W 00	0		
W 104	(HRLA) received a January 15, 2007 a the Department of I complaint indicated and safety were at a language in Improper physic b) Lack of transcriorders; c) Probable inadequicers; Due to the nature of investigation was in The findings of the i client observations, review of client and including incident re As a result of the fin made that the facility requirements in the and Management, a 483.410(a)(1) GOVE	itiated on January 16, 2008. Investigation were based on and staff interviews, and administrative records; ports. dings, a determination was / failed to comply with federal Conditions of Governing Body and Health Care Services. ERNING BODY	W 104	W104	2008 FEB 26 A 10: 53	BERARTHENT OF HEALTH HEALTH REGULATION ADMINISTRATION
	the governing body budget, and operatin	must exercise general policy, ag direction over the facility.				•
E C Id	Based on observation record reviews the graph policy to ensure the priders were signed vocal regulation [Title ensure that nurses we	not met as evidenced by: ns, staff interviews, and overning body failed to have at physician's telephone within 24 hours as required by 7, Subtitle D, Chapter 13]; to here adequately trained and		This Standard will met as evidenced Governing body will a current policy to enterphat physician's teleph	be by: mend sure hone	
WATORY E	MY MWII	R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	JK TITLE	21	25/08

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that a safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 is following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

tM CMS-2567(02-88) Previous Versions Obsolete

Event ID:5YJY11

Facility ID: 09G118

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PRINTED: 02/13/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \boldsymbol{c} B. WING 09G119 01/16/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE IDI. WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION 1D (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 104 WIOY, continued. Continued From page 1 W 104 orders are signed within practiced standard level of care. 24 hours The findings include: 1. Review of the physician's orders sheet (POS) 1. a, b & c on January 16, 2008 at approximately 8:10 AM All telephone orders dated 1/7/08 2/15/08 revealed that Client #1 had several telephone were signed by the PCP. Future orders that had not been signed by the facility's telephone orders will be faxed to the Ongoing Primary Care Physician (PCP) within twenty-four PCP upon receipt of the orders for (24) hours as documented below: review and signature. The PCP will fax a. January 7, 2008; the signed telephone orders back to the facility for filing in the clients' records. Primidone 250 mg one tablet via gastric tube This process will ensure that telephone every eight hours: orders are signed by the PCP within 24 hours of order. In addition the RN - Keppra 750 mg one tablet via gastric tube Supervisor will every twelve hours: conduct regular oversight and record reviews -Iron Sulfate 325 mg tablet twice a day via gastric tube: - Catapres 0.3 mg one tablet via gastric tube twice a day (hold for systolic pressure of less 110); -Colace liquid 25mg (100ml.) via gastric tube twice a day,

tube every six hours PRN

lesions:

daily:

-Mupirocin ointment 2% twice a day apply to

-Lasix solution 4 ml. (40mg) via gastric tube

-Muliti-vitamin tablet one via gastric tube;

-Tylenol solution 20.3 ml (650 mg) via gastric

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE (COMPL	
		09G119	B. WIN	G		01/	C 16/2008
NAME OF	PROVIDER OR SUPPLIER			451	ET ADDRESS, CITY, STATE, ZIP CODE 5 EDSON PLACE, NE ISHINGTON, DC 20019	, <u>, , , , , , , , , , , , , , , , , , </u>	10.2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ -	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
	(when ever necess - Fleets enema or movement in two days b. January 9, 2008: - Discontinue Multitube and start Stress formula with Zinc c. January 14, 2008: - Accuzyme ointmeterarm and wrist to debride eschar; and curasol gel to all the licensed Practic 16, 2008 at approximacknowledged that the verbal telephone ord	sary); and he rectally PRN if no bowel hys. i-vitamin tablet one via gastric s one tablet via gastric tube; ent to necrotic wound on right healthy tissue to promote cal Nurse (LPN) on January	W 1	04	-		
1 1 2	that nurses were ade standard level of care a [Cross Refer to 33: ensure adequate trail	to have a policy to ensure quately trained and practiced as evidenced below: 9.2] The facility failed to ning for nursing staff to only	·	2.	a. Reference response to W	339.2	
t e	he PCP for Client #1 Cross Refer to 33sensure adequate train	9.3] The facility failed to hing for nursing staff to R according to the Principles			b. No deficiency cited W 33 the deficiency report.	9.3 on	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1	TIPLE CONSTRUCTION	(X3) DATE S	
	· · · · · · · · · · · · · · · · · · ·	09G119	B, WING_		J	C 16/2008
NAME OF	PROVIDER OR SUPPLIER			REET ADDRESS. CITY, STATE. ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	JULD BE	(X5) COMPLETION DATE
W 104		age 3 entation for Client #1.	W 104			
W 114	ensure adequate tr ensure that medica with the PCP's orde		102 - 44	c. Reference response to W 3	68	
VV 174	Any individual who	makes an entry in a client's it legibly, date it, and sign it.	W 114	This Standard will be evidenced by:	met as	
	Based on staff inter facility failed to ensi Medication Adminis	s not met as evidenced by: view and record review, the ure that entries onto a client 's tration Records were signed t investigated. (Client #2)		RN will provide appropriate follow-up to include du outron for failure to	- 17 1 - 4)
	January 15, 2008 at revealed that docum	dated January, 2008 on approximately 9:25 AM nentation was crossed out and on the MAR as evidenced		RN' continues to provide training and monitoring this area.	nog in	
	via gastric tube was January 7, 2008, inc been discontinued.	st 10, 2007 for the 0 ml. of water every six hours crossed out and dated (icating that the order had There was no indication as to made the deletion on the		a, b, c, d & e A training for the nursing scheduled for 2/28/08 to acceptable practice when delidiscontinuing medications records. This will include apprintial/signature to identify the	address eting or on the	2/28/08 & Ongoing
	gastric tube was cro 7, 2008, indicating th	st 10, 2007 for the opra 750 mg twice daily via seed out and dated January at the order had been was no indication as to the		reason for deletion. In addition Supervisor will conduct oversight & record reviews.	the RN regular	

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STATEME AND PLAT	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION ING	(X3) DATE	SURVEY PLETED
	·	09G119	B. Wil	NĢ.		01	C /16/2008
NAME OF	PROVIDER OR SUPPLIER				reet address, city, state, zip code 4515 Edson Place, ne Washington, DC 20019	01/	110/2003
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTOR (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRIES OF THE A	JUD BE	(XS) COMPLETION DATE
W 114		ge 4 ade the deletion on the MAR.	W	114		· · · · · · · · · · · · · · · · · · ·	
	day via gastric tube January 7, 2008, ind been discontinued.	st 10, 2007 for the midone 250 mg three times a was crossed out and dated icating that the order had There was no indication as to made the deletion on the					
	a daily for nutritional was crossed out and indicating that the on	n Sulfate 325 mg tablet twice supplement via gastric tube dated January 7, 2008, der had been discontinued. tion as to the staff person					
	at approximately 9:26 that the nursing staff without initialing the e Principles of Nursing	ne LPN on January 16, 2008 AM it was acknowledged crossed out documentation entries according to the Documentation. There was ence that the nursing staff IAR according to the Documentation.					
W 159	federal deficiency rep 483.430(a) QUALIFIE RETARDATION PRO	D MENTAL FESSIONAL	`W 15	-	W159 This Gondard will be me evidenced by:	t as	
	integrated, coordinate qualified mental retard	eatment program must be d and monitored by a dation professional.					

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DEPARTMENT OF HEALTH	I AND HUMAN SERVICES
CENTERS FOR MEDICARE	& MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ILTIPLE CONST DING	TRUCTION	0	(3) DATE S COMPLI	
		09 G 119	B. WIN	>		Ì		C 6/2008
NAME OF	PROVIDER OR SUPPLIER			4515 ED\$Q	ESS. CITY, STATE, ZIP C IN PLACE, NE ITON, DC 20019	ODE	<u> </u>	W.2000
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CO ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	N SHOULI APPROF) BE	(X5) COMPLETION DATE
W 159	This STANDARD Based on interview Qualified Mental R (QMRP) failed to a services for one of (Client #1) The finding include 1. Cross Refer to coordinate service Team (IDT) to ens Management Care recommendation to was addressed. 2. On January 16, AM Client #1 was a side. The bed did The facility's Licens interviewed on Jan 8:10 AM and acknow have a pressure m Review of Client #1	is not met as evidenced by: w, and record review, the Retardation Professional ensure the coordination of f one client in the investigation. es: W322.1. The QMRP failed to s with the Interdisciplinary rure that Client # 1's Health e Plan's (HMCP) o obtain a pressure mattress 2008, at approximately 7:40 observed lying in bed on his left not have a pressure mattress. sed Practical Nurse (LPN) was uary 16, 2008 at approximately owledged that Client #1 did not attress on his bed. I's HMCP updated on January	W 1	1 & 2 mattressince h 2007, pressure except f wrist w scab for		ss) on he lity in a liter 2/08. A letely let	March mating ll the healed	2/16/08 Ongoing
	7, 2008, on Januar 8:00AM recommen the client's bed to a integrity. Review o dated January 7, 20 approximately 8:15 multiple Stage I to Shis hips, bi-laterally heel, left buttocks a evidence that the client signature.	y 16, 2008, at approximately ided a pressure mattress for assist in preserving skin of the nursing progress notes 2008, on January 16, 2008 at AM revealed Client #1 had Stage II decubitus ulcers on right wrist, back, left foot, left and left knee. There was no lient had a pressure mattress mmended by the HMCP.	W 32	w32	2 Z			

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		09 G 119	B. Wil	NG	01/	C 16/2008
NAME OF	PROVIDER ()R SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP O 4515 EDSON PLACE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		IN SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 322		ovide or obtain preventive and	W s	322		
	Based on observation review the facility's fall that the facility's falled the facility falled that the facility for the application of dressing; and failed tissue site(s) for the	s not met as evidenced by: on, interview and record alled to directly assess Client on to the facility from a to address recommendations al consultants for Client #1; the specific pressure areas f the hydrocolloid wound to specify the specific healthy application of the curasol gel one client in the investigation.		This Standard under the met as evidence	عآلا له ط لهين :	
	December 12, 2007 seizure disorder and The client was disch with diagnoses of se Infection (UTI), anen alterations in fluids, a physician falled reast to the facility and to vere-admission orders following: a) Interview with the (LPN) on January 16 AM revealed that the (PCP) was the client'he was hospitalized.	ed to a local hospital on with admitting diagnoses of urinary tract infection (UTI), arged on January 7, 2008 izure disorder, Urinary Tractinia, Bullous disease, and electrolytes and nutrition. The sess the client as his return verify the implementation of		a. Since the PCP was physician during the hospitalization the PCP gradmission orders upon the to the facility. The client with the PCP on 1/19, 2/9 & then as evidenced by the dof these visits in the client nursing staff will ensure will assess the client upon from hospitalization.	ave telephone client's return vas visited by 2/16/08 since locumentation s'r record. The that the PCP	2/19/08 and Ongoing

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		I AND HUMAN SERVICES & MEDICAID SERVICES	4		FORM): 02/13/2008 1 APPROVED): 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE S	URVEY
		09G119	B. WING_		01/1	C 6/2008
ID!	PROVIDER OR SUPPLIER		^	REET ADDRESS, CITY, STATE, ZIP ¢ 4515 EDSON PLACE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
1	evidence that the Policy by On January 16, 29:18 AM Client #1's were reviewed. The admission orders precan daily at 7:00 AM 8:00 PM). The reco "Nutritional Re-admi January 8, 2008. The that Client #1's gastroto Resource 2.0, five AM, 4:00 PM, 8:00 PT anscribed on the condinistration Recoi (five cans daily at 7:08:00 PM and 12:00 nm There was no docum addressed the nutrition Client #1's gastric tub Resource 2.0, five cand AM, 4:00 PM, 8:00 PM and 12:00 nm There was no docum addressed the nutrition Client #1's gastric tub Resource 2.0, five cand AM, 4:00 PM, 8:00 PM and 12:00 pm and 12	2008 between 8:10 AM and medical and clinical records revealed telephone ated January 7, 2008. The escribed Resource 2.0 (one 1.11:00 AM, 4:00 PM and rds also revealed a ssion Evaluation dated a evaluation recommended in tube feedings be increased a cans daily at 7:00 AM, 11:00 PM, and 12:00 midnight. Silient's Medication rd (MAR) was Resource 2.0 PM, and 11:00 AM, 4:00 PM, and 11:00 AM, 4:00 PM, and 11:00 AM, 11	W 322	b, c & d. The PCP was Nutritionist recommend 1/8/08 on 1/9/0 recommendations were renurse on 1/9/08. The PCP recommendations and telephone orders on 1/9/08 were written and transcr MAR on 1/9/08. (See attack)	lations dated 18. These eccived by the approved the gave the 3. These orders ribed onto the	1/9/08 and Ongoing

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		AND HUMAN SERVICES & MEDICAID SERVICES		•	PRINTED: 02/13/20 FORM APPROVE	E
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL	LTIPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	3
· ·		09G119	B. WING		C 01/16/2008	
NAME OF	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTIO	'n
W 322	d) On January 16, 29:23 AM Client #1's were reviewed. The admission orders, d telephone orders pn (daily mixed with 30 Review of the Nutrit dated January 8, 20 recommendation for Protein Powder threm of water via gastr 9, 2008 MAR indicat administering one so Powder three times as ordered by the ph	2008 between 8:11 AM and medical and clinical records revealed telephone ated January 7, 2008. The escribed Prosource 30 ml ml of water via gastric tube), conal Readmission Evaluation 08 revealed a revealed a record record record with 30 ic tube. The client's January ed that the nurse started coop of Prosource Protein a day instead of once a day sysician.	W 32	2		
	Summary dated Jan 2008 at approximate Client #1's discharge Lovenox 40 mg subd	#1's hospital Discharge pary 7, 2008 on January 16, by 8:12 AM revealed that medications included sutaneously every day. This las a prophylaxis while in the		e. The PCP did not order the Las a part of the readmission order claimed the client did not need if facility since he was being reposand gotten out of bed frequently.	ers. He t at the	
	January 7, 2007 at 4:	l's nursing notes, dated 00 PM revealed the of Client #1's pressure	. ,	f. The nurses will be re-train clarifying unclear orders or directing 2/28/08. In addition the nurses we trained on a new form developed	ves on & Ongoing	
	Two Stage II pressumeasuring 3 x 4 cm;	re areas on the right hip			phone	j
	wrist spreading up the measuring 3 x 4 cm c	eas bi-laterally on the right arm towards the elbow on the inner aspect of the n the outer aspect of the		RN will continue to mond and provide direction as needed for UN STAFF to	5 0	
	Stage I pressure area	on the left hip;		further ensure complia	me	

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DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES		•): 02/13/2008
		& MEDICAID SERVICES				1 APPROVE[). 0 <u>938-039</u> 1
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		09G119	B. WIN	G	- 01/	C 16/20 <u>08</u>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
ID1		·	•	4515 EDSON PLACE, NE WASHINGTON, DC 20019		
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W 322	Continued From page	ge 9	W 32	22 W3ZZ,,,		
	Five Stage I pressur back measuring 2 x	re areas on the left side of the 2 cm;		with this stand	and	
	Stage II pressure at foot near the little to	reas on the left side of left e measuring 2 x 2 cm;				
. ;	Stage I and Stage II heel;	pressure areas on the left				
	Stage I pressure on	left knee;				
	Stage I pressure ulc	er on left buttocks and				
	Stage I pressure are	a on the left hip.				
	orders dated January 2008 at approximate Client #1 had an orded dressing over pressure vealed that the dresevery three days and necessary). The facill Nurse (LPN), interview approximately 8:30 Aprimary care physicial pressure areas for the hydrocolloid wound die colloid wound die c	lity's Licensed Practical wed on January 16, 2008 at M, acknowledged that n did not specify the specific				
i a la l	January 14, 2008, on approximately 8:07 An ad an order for "cura o promote healing". I an January 16, 2008 a	an's telephone orders dated January 16, 2008 at If revealed that Client #1 sol gel to all healthy tissue If an interview with the LPN at approximately 8:40 AM it at Client #1's physician's				

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NAME OF	PROVIDER OR SUPPLIER		·	STE	REET ADDRESS, CITY, STATE, ZIP CODE		
IDI				4	IS15 EDSON PLACE, NE VASHINGTON, DC 20019	•	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 322	Continued From pa	ne 10	w a	22			<u> </u>
	telephone orders did healthy tissue site (streatment There wand physician's telephorespecific healthy tissue)	d not specify the specific s) to apply the curasol gel s no evidence that the le orders specified the ue site (s) for the application eatment. Additional the nurse	, , ,				
W 331	483.460(c) NURSIN		wз		W331		
	The facility must pro services in accordar	vide clients with nursing nce with their needs.			This Standard will be a conserved by:	met	
	Based on observation review the facility fail	not met as evidenced by: on, staff interview and record led to ensure nursing ice with the needs of one of stigation. (Client#1)			·		
ì	The findings include:			1		ļ	
	Cross Refer to W staff failed to transcr Medication Administr prescribed by the PC	339.1 The facility's nursing libe a medication order on the ation Record (MAR) P for Client #1.		۸,	1. Reference response to W 3	39.1	
	failed to ensure that i	68. The facility's nursing staff medications were given in physician's orders for Client	·		2. Reference response to W 36	58	
•	staff failed to clarify th	22.1. The facility's nursing ne physician's orders for the rocolloid wound dressing pressure areas.			3. Reference response to W 32	2 F	
1	staff_failed to clarify t	22.2. The facility's nursing he physician's orders for the asol gel treatment to Client			4. Reference response to W 322	F	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPL	PLETED	
· ·		09G119	B, WING_		01/1	C (6/2008	
NAME OF F	PROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CODE 1515 EDSON PLACE, NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 331	staff transcribed di were not prescribe [This is a repeat defederal deficiency re 483.460(c)(4) NUR Nursing services m	site (s). 139.2. The facility's nursing etary orders on the MAR that d by the PCP for Client #1. eficiency. Please refer to report, dated 10/05/07]	W 331 W 339	W339 This Standard well be m evidenced by	as ten		
	Based on interview Licensed Practical physician's orders valient investigated. The findings included. The facility's nursimedication order or prescribed by the Parameter of the nursimal January 7, 2008, or approximately 8:15 had Stage II pressoright wrist spreading elbow measuring 3 the wrist and measurappect of the wrist telephone order dat that Client #1 was p	sing staff failed to transcribe a the MAR for Client #1 as CP as evidenced by: In progress notes dated a January 16, 2008 at AM revealed that Client #1 are areas bi-laterally on the gup the arm towards the x 4 cm on the inner aspect of aring 11 x 3 cm on the outer Review of the physician's ed January 14, 2008 revealed rescribed "Accuzyme wound on right forearm and		1. The nursing staff will be ron administering treatment acc the physician's order/instruct addition, nurses will clarify or the PCP if instructions are Additionally the RN Supervicenduct regular record Reference response to W 322.	ording to ion. In ders with unclear.	2/28/08 & Ongoing	

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	TMENT OF HEALTH AND HUMAN SERVICES RS FOR MEDICARE & MEDICAID SERVICES	:		FORM	0: 02/13/2008 MAPPROVED 0: 0938-0391
STATEMEN	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(' '	NULTIPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
	096119	B. Wir	NG	046	C
NAME OF	PROVIDER OR SUPPLIER	<u> </u>			16/2008
IDI	THOUBER OR GOFFEIER	•	STREET ADDRESS, CITY. STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019	;	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRI	HOULD BE	(XS) COMPLETION DATE
W 339	Continued From page 12	w:	339		
W 368	2. [Cross Reference W322] The facility's nursing staff transcribed on Client #1's MAR and implemented dietary recommendations from the nutritionist that were not prescribed by the PCP. 483.460(k)(1) DRUG ADMINISTRATION	ws	2. Reference response to W 322 b, c & d	 : ,	
	The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.		This Standard will be as evidenced by.		
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that medications were given in compliance with the physician's orders for one of one client in the investigation. (Client #1)		RN will address LPN s failed to administer n in compliance with ph orders.	nedication ysician's	\$
	The finding includes:				
Í	On January 16, 2008 Client #1 was observed in his bed lying on his left side. The client's right right forearm was observed with multiple healing areas. Fleview of the nursing progress notes dated January 7, 2008 revealed that Client #1 had Stage II pressure areas bi-laterally on the right wrist spreading up the arm towards the elbow measuring 3 x 4 cm on the inner aspect of the wrist and 11 x 3 cm on the outer aspect of the wrist.		The nursing staff will be re 2/28/08 on transcribing medication and or treatmen MAR as soon as the order in The treatment was transcribe MAR on 1/16/08 and was in 1/16/08 when the medication available. In addition the RN will conduct regular over record review. (See attachments)	orders of t onto the s received. d onto the nitiated on on became Supervisor sight and	2/28/08 & Ongoing
	Review of the physician's telephone order dated January 14, 2008 on January 16, 2008 at approximately 8:10 AM revealed that Client #1 was prescribed "Accuzyme ointment to necrotic wound on right forearm and wrist to debride eschar". In an interview with the Licensed Practical Nurse (LPN) on January 16, 2008 at		record review. (See ausenmen	L#4)	

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STATEMENT OF DEPOSITION (X) PROMOBERCIAN NUMBER (X) PROMOBER CAR SUPPLIEN (DIGHTER CATION NUMBER (DEPART	MENT OF HEALTH	I AND HUMAN SERVICES & MEDICAID SERVICES				FORM OMB NO.	02/13/2008 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER ID I SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 368 Continued From page 13 approximately 8:55 AM it was acknowledged that 'Accuzyme ointment to necrotic wound on right forearm and wrist to debride eschar "was not transcribed on Client#1's January, MAR and that the client had not received the medication. Review of the January, MAR on January 16, 2008 at approximately 9:00 AM revealed no documented evidence that Client #1 had received Accuzyme ointment to his necrotic wound on right forearm and wrist in compliance with the	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1.		i	COMPLE	TED
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 368 Continued From page 13 approximately 8:55 AM it was acknowledged that "Accuzyme ointment to necrotic wound on right forearm and wrist to debride eschar" was not transcribed on Client#1's January, MAR and that the client had not received the medication. Review of the January, MAR on January 16, 2008 at approximately 9:00 AM revealed no documented evidence that Client #1 had received Accuzyme ointment to his necrotic wound on right forearm and wrist in compliance with the	1		09G119	B. Wil	NG		1	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 368 Continued From page 13 approximately 8:55 AM it was acknowledged that forearm and wrist to debride eschar " was not transcribed on Client#1's January, MAR and that the client had not received the medication. Review of the January, MAR on January 16, 2008 at approximately 9:00 AM revealed no documented evidence that Client #1 had received Accuzyme ointment to his necrotic wound on right forearm and wrist in compliance with the		ROVIDER OR SUPPLIER			4	515 EDSON PLACE, NE		
W 368 Continued From page 13 approximately 8:55 AM it was acknowledged that "Accuzyme ointment to necrotic wound on right forearm and wrist to debride eschar " was not transcribed on Client#1's January, MAR and that the client had not received the medication. Review of the January, MAR on January 16, 2008 at approximately 9:00 AM revealed no documented evidence that Client #1 had received Accuzyme ointment to his necrotic wound on right forearm and wrist in compliance with the	, IDI	<u></u>			У		TION	(45)
approximately 8:55 AM it was acknowledged that "Accuzyme ointment to necrotic wound on right forearm and wrist to debride eschar " was not transcribed on Client#1's January, MAR and that the client had not received the medication. Review of the January, MAR on January 16, 2008 at approximately 9:00 AM revealed no documented evidence that Client #1 had received Accuzyme ointment to his necrotic wound on right forearm and wrist in compliance with the	PREFIX	/EACH DEFICIENC	V MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION DATE
	W 368	approximately 8:55 "Accuzyme ointme forearm and wrist i transcribed on Clie the client had not r Review of the Jan 2008 at approxima documented evide Accuzyme ointmer forearm and wrist i	AM it was acknowledged that int to necrotic wound on right to debride eschar " was not ent#1's January, MAR and that eceived the medication. uary, MAR on January 16, itely 9:00 AM revealed no ince that Client #1 had received it to his necrotic wound on right in compliance with the	W:	368			
				·				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) MUL A. BUILDI B. WING	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
09G119				P. WING		01/	16/2008
NAME OF F	4515 ED			DRESS, CITY, SON PLACE STON, DC:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
1 000	INITIAL COMMENT Surveyor: 19076	rs	. •	1 000			
	The Health Regulation (HRLA) received a control of January 15, 2007 at the Department of Ecomplaint Indicated and safety were at real improper physicol by Lack of transcription of Probable inadeculars: Due to the nature of investigation was initing findings of the inclient observations served.	clan documentation; ption of Physical The quate medical orders this complaint, an itiated on January 7, nvestigation were ba staff and consultant ew of client and admi	on PM from DS). The health rapy; to treat 2008. sed on				
	3508.1 ADMINISTR, Each GHMRP shall administrative supported to the resident Habilitation plans. This Statute is not in Surveyor: 19076	provide adequate ort to efficiently meet its as required by the net as evidenced by:	sir	l 180	3508.1 This Statute will be no evidenced by:	net as	2.16.08 ongoing
	Based on observation review, the GHMRP administrative supposefficiently meet the name in the investigation as habilitation plans. (R	failed to ensure aded of had been provided leeds for one of one it is required by their lesident # 1)	l to		,		
	tion Administration						

Mung Branch
JORATORY DIRECTOR'S OR PROVIDER'S SUPPLIER REPRESENTATIVE'S SIGNATURE

Director Residential Services

(X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING				
		09G119	·	B. WING_		01/	C 16/2008
NAME OF P	PROVIDER OR SUPPLIER				STATE, ZIP CODE	-	
IDI:		÷ ,		SON PLACE, GTON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIE Y MUST BE PRÉCEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
l 180	Continued From pa	ge 1		I 180			
	policy to ensure that were signed within a regulation [Title 7, 8 evidenced by the formula of the property of	nysician's orders she 8 at approximately 8: #1 had several telep been signed by the fi cian (PCP) with-in tw mented below: g one tablet via gastric mg tablet twice a day one tablet via gastric systolic	ne orders by local 3] as et (POS) 10 AM bhone acility's renty- four ric tube tube tube tube		1. a, b & c Reference response to	W 1 90 f	2.15.08 angoing
	·	il. (40mg) via gastric	tube				
	-Muliti-vitamin table	et one via gastric tubi	e;				
ith Regulat	ion Administration		l.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N			(X2) MULT A. BUILDII B. WING	TIPLE CONSTRUCTION		C FELED .	
<u>'</u>	_ 	09G119				01.	/16/2008
NAME OF	PROVIDER OR SUPPLIER	· -	4515 EDS	DRESS, CITY, SON PLACE STON, DC 2			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	Hould be	COMPLETE DATE
1 180	Continued From pa	ge 2		I 180		·· ·	
	tube every six hours (when ever necess - Fleets enema or movement in two da	sary); and ne rectally PRN if no					
-	b. January 9, 2008;				•		
	gastric tube and sta formula with Zinc c. January 14, 2008 - Accuzyme ointme forearm and wrist to debride eschar; ar -Curasol gel to all healing.	one tablet via gastrice: ent to necrotic wound and healthy tissue to proceal Nurse (LPN) on Justely 10:00 AM the PCP had not signifers with-in twenty-for	on right mote anuary ed				
	Cross Refer to W1 Qualified Mental Ret (QMRP) failed to ens services for Resident	ardation Professiona sure the coordination			2. Reference response to W	159	2.26.08 ongoing
,	3. Cross Refer to W : failed to ensure that t were provided in acco Resident #1.	the facility's medical :	services	-	3. Reference response to W	322	
<u></u>	4. Cross Refer to W3	31. The governing b	ody		4. Reference response to W	331 :	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A BUILD		(X3) DATE SURVEY COMPLETED			
-	,	09G119		B. MING		N4/	C 16/2008
NAME OF PROVIDER OR SUPPLIER STREET			STREET AD	DRESS. CITY	STATE ZIP CODE	<u> </u>	10/2008
			4515 EDS	ON PLACE	, NE		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
J 180	Continued From page	ge 3		1 180		· · · · · ·	
	failed to ensure that provided nursing seneeds of Resident#	rvices in accordance	staff with the				
	Cross Refer to W failed to ensure that included other nursing physician for Reside	the facility's nursing ng care as prescribe	services		5. Reference response to W 3	339	
	6. Cross Refer to W368. The governing body failed to ensure that the facility's nursing staff administered medications in compliance with the physician's orders for Resident #1.		staff		6. Reference response to W 3	368	
1 230	3510.5(g) STAFF TF	RAINING		1230	STAFF TRAINING		
	Each training program limited to, the following	m shall include, but i ng:	not be		This Statute will be a as evidenced by:	net	
	(g) Habilitation plann	ing and implementat	ion;				
	This Statute is not m Surveyor: 19076	net as evidenced by:					
	The findings include. 1. Review of the phystelephone orders date January 16, 2008 at a revealed that Reside weighed weekly. The assessment indicated sustained a significant recommended weekly revealed that the reside HBW) was 118-156 phovember 2007 there weight loss (110.9 lbs in December, 2007 tovember 2007). Revion Administration	sician's re-admissioned January 7, 2008, approximately 9:05 Ant #1 had an order to a facility's nutritionist' that the resident hat weight loss and weights. The assetent's Healthy Body bounds, however sine had been a 22 pour on January 7, 2008, 7 and 132 pounds in	on M o be s d d essment Weight ce nd 118.4		1. Weekly weights were take documented on the weekly weight located in the MAR. Weights were on 1/7, 1/12, 1/19, 1/26, 2/2, 2/2 respectively. The weight loss was 2 recent hospitalizations and s since 11/07. His current weight 2/16/08 is 112.2 lbs. The nutrinursing and medical staff contimonitor his weight weekly.	e taken 9, 2/16 due to surgery as of	1/12/08 Ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	A. BUILDIN		(X3) DATE \$1 COMPLE	TED :	
		09G119		B. WING		01/1	6/2008
NAME OF P	ROVIDER OR SUPPLIER		4515 EDS	DRESS, CITY, S ON PLACE, STON, DG 2	0019		
(X4) ID PREFIX TAG	/EACU ひを聞けばらい	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL !	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP) DEFICIENCY)	OULD BE.	COMPLETE DATE
1 230	January 16, 2008 a revealed that Residueld that I are residueld to a subject of the Residueld that Residueld th	ated January 7, 2008 at approximately 9:12 fent #1's last docume bounds on January 7, sed Practical Nurse (uary 16, 2008 at appedged that Resident #since January 7, 2008 d evidence that the rely as recommended lician (PCP) and Nutre 19339.1 The facility fa	AM ented , 2008. LPN), roximately 1 had 8. There resident by the ritionist.		2. Reference response to W	339.1	2.28.08
	transcribing medica Administration Rec the PCP for Reside 3. Cross Refer to 3 ensure adequate tr	39.2. The facility fail aining for the nursing ers that were prescril	ledication libed by led to g staff to	ŧ	3. Reference response to W	339.2	ongo ing
	ensure adequate tr document on the M Priniciples of Nursin Resident; #1. 5.Cross Refer to W ensure adequate tr ensure that medica	39.3. The facility fail aining for the nursin IAR according to the ng Documentation for Jack. The facility fails aining for nursing stations were given in a PCP's orders for Research and the pCP's orders for Research aining stations.	g staff to or ed to aff to		4. Reference response to W 33 5. Reference response to W -		
	PROVISIONS Professional service	ON SERVICES: GET es shall include both luding identification o	diagnosis	1401			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED:		
		09G119 '		B. WING_		01/1	6/2008
4515 ED				ODRESS, CITY, STAYE, ZIP CODE SON PLACE, NE GTON, DG 20019			
(X4) ID PREFIX TAG	/EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES.)	IULD BE	(X5) COMPLETE DATE
1 401	services, and services	ige 5 ils and needs, treatm ces designed to prev her loss of function t	ent	I 401			
	resident.	met as evidenced by			This statute will be evidenced by:	metas	
	review the facility's Resident #1 upon na hospital stay; falle recommendations reconsultants for Reside specific pressurate hydrocolloid wo specify the specific application of the circulation.	ion, interview and rec failed to directly asse e-admission to the fa ed to address made by the medical sident #1; and failed to re areas for the appli- und dressing; and fa healthy tissue site(si urasol gel treatment investigation. (Resid-	o specify cation of iled to for the for one of				
	December 12, 2007 seizure disorder an The resident was di with diagnoses of s Infection (UTI), ane alterations in fluids, physician failed to e received appropriat from the hospital as	dmitted to a local hos with admitting diagram of with admitting diagram of which are the contract infectors of the contract of	noses of on (UTI). y 7, 2008 ary Tract the ary and of the ary the a				
-	(LPN) on January 1 AM revealed that th (PCP) was the resid while he was hospit on January 13, 2006	e Licensed Practical 6, 2008 at approxima e Primary Care Phys dent's attending phys alized. The LPN stat 8 (6 days after his dis e facility to assess th	ately 8:50 lician lician ted that scharge)	:	a. Reference response to W 3	322 а	2.28.08 ongoing

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTTION IDENTIFICATION NUMBER:			1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
±.				A. BUILDIN B. WING_		-	C	
	· · ·	09G119				01/	16/2008	
NAME OF P	PROVIDER OR SUPPLIER			•	STATE, ZIP CODE			
וסו			,	ISON PLACE, NE IGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
· I 401	Continued From pa	ige 6		1401				
	resident, however, assessment	there was no evidenc	ce of his					
				b, c & d Reference responding W 322 b, c & d	ase to			
,	Primary Care Physic added can of Resou	the LPN alleged that cian (PCP) was awan irce, he did not chand an's order sheet (PO	e of the					
1	PCP addressed the recommendation tha feedings be increase	nented evidence that nutritionist 's at Resident #1's gastr ed to Resource 2.0, fi 00 AM, 4:00 PM, 8:0	ric tube					
s r t	9:21 AM Resident#1 records were reviewe	008 between 8:11 Al I's medical and clinic ed. The records reve orders, dated Janua	al ealed					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN B. WING	- -		ETED		
		09G119				1 01/1	6/2008	
NAME OF P	ROVIDER ()R SUPPLIER			DORESS, CITY, STATE, ZIP CODE				
IDI				SON PLACE STON, DC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE ≅ APPROPRIATE	(X5) . COMPLETE DATE	
1 401	Continued From pa	ge 7	·	1401				
	2008. The telephor to flush gastric tube before and after ear of the Nutritional Re January 8, 2008 revincrease water flush feeding. The reside nurse started flushin of water on January LPN, interviewed or approximately 9:22, nursing staff was for recommendation to each feeding. Althor Primary Care Physical nutritionist recommendation revise his orders refered to flush the primary Care Physical Nutritionist recommendation revise his orders refered to flush the primary Care Physical Nutritionist recommendation for the primary Care Physical Nutrition for the primary Physical Nutrition for the primary Physical Nutrition for the primary Physical Nutrition for the phys	ne orders prescribed with 30-60 ml. of wach medication pass. eadmission Evaluation realed a recommend nes to 200cc after earl's MAR indicated the gastric tube way 9, 2008 at 4:00. The January 9, 2008, at acknowledged that llowing the nutritionis flush with 200cc was ugh the LPN alleged cian (PCP) was award addition, the physicial flect the increased to 2008 between 8:11 A 1's medical and clinical red. The records reven orders, dated January and the Nutrition attendation for one scoop of the Nutrition dated January and the prescribed ally mixed with 30 ml wiew of the Nutrition attendation for one scoop of the Nutrition dated January and the prescribed ally mixed with 30 ml wiew of the Nutrition attendation for one scoop of the Nutrition of the Nutrition attendation for one scoop of the Nutrition of the Nutrition attendation for one scoop of the Nutrition of the Nutrition attendation for one scoop of the Nutrition of the Nutrition attendation for one scoop of the Nutrition of the Nutrition attendation for one scoop of the Nutrition of the Nutrition attendation for one scoop of the Nutrition of the Nutrition of the Nutrition attendation for one scoop of the Nutrition of the Nutrit	reter Review on dated lation to lach hat the ith 200cc le facility's the st ter after that the re of the an did not lealed lary 7, of water al se, 2008 op of day, e. The day ledged lary 9, ledged lay re of the					
	any changes to his c	nuel.						

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPI IDENTIFICATION N				TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G119		A. BUILDII B. WING		C 01/16/2008
NAME OF	PROVIDER OR SUPPLIER	·	STREET AL	DRESS, CITY,	STATE ZIP CODE	1
IDI				SON PLACE STON, DC		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SG IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
1 401	Continued From pa	ge 8		1 401		
	Summary dated Jai 2008 at approximate Resident #1's disch Lovenox 40 mg sub medication was use the hospital. The LF 16, 2008 at approximate acknowledged that addressed the hospital to recessive the hospital to recessive the hospital for the LP January 7, 2007 at 4 following description ulcers: Two Stage II pressure as wrist spreading up the measuring 3 x 4 cm wrist and 11 x 3 cm wrist. Stage I pressure are Five Stage I pressure are Five Stage I pressure are foot near the little toe foot near the little toe	the PCP did not order the PCP did not order tital's recommendation tive Lovenox 40 mg. The nursing notes, day the areas on the right the arm towards the end on the inner aspect of the outer aspect of the areas on the left side of the areas on the left side of the measuring 2 x 2 cm the inner aspect of the areas on the left side of the measuring 2 x 2 cm	truary 16, I that cluded ay. This hile in anuary or or on for the ated assure at hip e right albow of the of the fieft;		f. Reference response to W 339 & W 322	2.2808 ongoing
, ,	neel;	pressure areas on the	ie left			·
1	Stage pressure on ion Administration	eft knee;			<u> </u>	
ATE FORM			686	3B EN	/ IV4+	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I B WING					
		09G119				01/1	6/2008
NAME OF	PROVIDER OR SUPPLIER		**		STATE, ZIP CODE		
IDI				ON PLACE TON, DC :			,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	:ULL .	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
1 401	Continued From page	ge 9		1401			
	Stage I pressure uld	er on left buttocks ar	ıd				
	Stage I pressure are	•					
	orders dated Januar 2008 at approximate	cian's re-admission te ry 7, 2008, on Januar aly 8:15 AM revealed order for "hydrocolloi	y 16, that	·			
,	dressing over press revealed that the dre every three days and	ure areas". Further re essing was to be char	nged nged				
	Nurse (LPN), intervie approximately 8:30 /	ewed on January 16, AM acknowledged tha an did not specify the	2008 at				
·	hydrocolloid wound o	dressing treatment in ditional the nurse fail					
	January 14, 2008, or	cian's telephone order n January 16, 2008 at AM revealed that Res	: 1				
	had an order for "cur to promote healing", on January 16, 2008	asol gel to all healthy In an interview with t at approximately 8:4	tissue he LPN 0 AM it				
	was acknowledged to telephone orders did healthy tissue site (s) treatment There was	not specify the speci to apply the curasol	fic gel				
	physician's telephone specific healthy tissu- of the curasol gel trei	e orders specified the e site (s) for the appli	cation				
	failed to clarify the or						
1 420	3521.1 HABILITATIO	N AND TRAINING		l 420	1420		
	Each GHMRP shall pater training to its resident tion Administration						

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		(X1) PROVIDER/SUPPLIE		A. BUILDI		(X3) DATE COMPI				
•		09G119		B. WING		01/	16/2008			
NAME OF P	ROVIDER OR SUPPLIER		4515 EDS	DRESS, CITY, SON PLACE STON, DC 2			· 			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH DEFICIENCY MUST BE PRECEDED BY FULL		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH GROSS-REFERENCED TO THE API DEFICIENCY)	IONTO BE	(X5) COMPLETE DATE
alth Regulat	and maintain those more effectively with environments and to of physical, mental. This Statute is not Surveyor: 19076 Based on observation review, the GHMRF and training to its rethem to acquire and cope with their environtinum levels of plunctioning for one investigation. (Resident Hindings included the findings included the f	e life skills needed to the the demands of the to achieve their optime and social functioning met as evidenced by ion, interview and receptable to provide has esidents that would edmaintain life skills reinments and achieve physical, mental and of one resident in the dent #1) es: // 322.1. The QMRP fawith the Interdiscipling rethat Resident #1's Plan (HMCP) or a pressure mattressed by: // 3, at approximately 7, served lying in bed ovation revealed that is ressure on his bed. Icensed Practical Nurses at approximately 8: that Resident #1 did and Review of Residelanuary 7, 2007, on Jensey en and served lanuary 8; served lanuary 7, 2007, on Jensey en and served lanuary 8; served lanuary 8	cord bilitation nable needed to ve social e e e e e e e e e e e e e e e e e e e	1 420	This Statute will be as evidenced by: 1. Reference response to W 3		2.16.08 ongoing			
ATE FORM			689	⁹⁹ 5	YJY11	lf continuațio	n sheet 11 of 11			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA VIBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
	-	09G119	_	B. WING_		01/16/2008
NAME OF P	RÖVIDER OR SUPPLIER		4515 EDS	ORESS, CITY, ON PLACE, TON, DC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
1 420	Continued From pa	ge 11		1420		_
	AM revealed Reside ulcers on his hips, to foot, left heel, left be from Stage I to Stage	6, 2008 at approximate the sent #1 had multiple of a had multiple of a had a had a pressure mattrested by the HMCP.	decuitus back, left ranging vidence			
1 473	3522.4 MEDICATIO	ONS		1473		
	The Residence Director shall report any irregularities in the resident 's drug regimens to the prescribing physician.		,	1473 3522.4.	e met	
	This Statute is not Surveyor: 19076	met as evidenced by			This Statute will be as evidenced by.	
	facility failed to ensu	view and record revi ure that any irregular or one of one resider oported to the prescri t #1)	ities in It in the			
•	The finding includes	5 :				·
	January 7, 2007 at 4	s nursing notes, date 4:00 PM revealed the n of Client #1's press	•		Reference response to W 339	2.28.08 ongoing
	Two Stage II press measuring 3 x 4 cm	sure areas on the rigi ;	ht hìp			
	wrist spreading up to measuring 3 x 4 cm	reas bi-laterally on the arm towards the elements on the inner aspect on the outer aspect	elbow of the		·	
alth Pegul	Stage I pressure are	ea on the left hip;		.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G119			(X2) MUL)'I A. BUILDÍN B. WING	IPLE CONSTRUCTION .	(X3) DATE SURVEY COMPLETED C 01/16/2008		
NAME OF F	ROVIDER OR SUPPLIER	090119	STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 01/1	0/2000
4515 EDS				SON PLACE, STON, DC 2	NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	Provider's Plan of Corre (Each Corrective action sh Cross-Referenced to the Ap Deficiency)	IOULD BE	(X5) COMPLETE DATE
1473	Continued From particles Stage I pressure a foot near the little to Stage I pressure or Stage I pressure or Stage I pressure or Stage I pressure und Stage I pressure and Review of the physionders dated Jahua 2008 at approximat Client #1 had an orders	ige 12 ire areas on the left side areas on the left side be measuring 2 x 2 cr i pressure areas on left knee; cer on left buttocks ar	of left n; the left elephone ry 16, that	i 473			
	revealed that the drevery three days an necessary). The far Nurse (LPN), interviapproximately 8:30 primary care physic pressure areas for thydrocolloid wound telephone order. Acclarify the order. Review of the physic January 14, 2008, o approximately 8:07 what an order for "culto promote healing", on January 16, 2008, was acknowledged to the promote of the physic to promote healing".	essing was to be cha	inged 2008 at at at at a specific in his led to at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION. (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER (X1) PROVIDER/SUPPLIER/C		R/CLIA MBER:	A, BUILDING		COMPLE	DATE SURVEY COMPLETED C	
		09G119				01/1	6/2008
IAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
101	DI 4515 ÉC WASHIN				NE 0019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	(X5) COMPLETE DATE	
1473	Continued From pa	ge 13		1 473			
	treatment There was physician's telephon specific healthy tiss	(s) to apply the curas as no evidence that the corders specified the cue site (s) for the appreatment, Additional torder.	ne he plication				
1 500	3523.1 RESIDENT	'S RIGHTS		1 500			
	that the rights of resprotected in accord	dence director shall e sidents are observed ance with D.C. Law 2 applicable District an	l and 2-137, this				
	This Statute is not Surveyor: 19076	met as evidenced by	г.		This Statute will as evidenced by:	be met	
	review, the Group H Retardation (GHMR protect the rights of	on, interview and red dome for Persons wit RP) failed to observe a resident, in accord (now Title 7, Chapt	th Mental and lance				
	The finding include:	•				· .	i
	facility failed to ensi	(g). [Formerly 6-1969 ure the resident's right adequate medical a	nt to [
	on January 16, 2008 revealed that Resident orders that had not	nysician's orders she 8 at approximately 8: ent #1 had verbal tel been signed by the F P) with-in twenty- fou below;	10 AM ephone Primary				
	1. January 7, 2008:	<u></u>			· · · · · · · · · · · · · · · · · · ·		

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STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		(X3) DATE COMPI		
		09G119		B. WING		01/	16/2008	
NAME OF F	PROVIDER OR SUPPLIER	·	STREET ADDR		STATE, ZIP CODE			
וטו	· · · · · · · · · · · · · · · · · · ·		Washingt	ON, DC	20019			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
1 500	Continued From page	ge 14		1 500			1/7/08	
	every sight hours; - Keppra 750 mg o every twelve hours;	g one tablet via gastr one tablet via gastric t mg tablet twice a day	tube		A. 1. Keppra 750mg & Colad 5ml & Catapress 0.3mg were st 1/7/08. They were available. Pr 250mg, Iron Sulfate, M ointment, Lasix 40mg, Mult tablet were all administered w hours of admission. Tylenol at enema are PRN medications.	arted on imidone upirocin ivitamin ithin 24	Ongoing	
	twice a day (hold for pressure of less 1 -Colace liquid 25m; twice a day; -Mupircicin ointmentesions;		tube		RN will continue to continue to continue tile reviews to direction and feedbatto all muses as me RN will implement discontinue as waranted.	ck aded.		
	-Tylenol solution 20 tube every six hours		Ī					
	(when ever necess) - Fleets enema one movement in two day	e rectally PRN if no b	owel				, ,	
	gastric tube and stan	one tablet via gastric			2. Multivitamin discontinued or last dose given on 1/9/08 at 8 ar order on 1/9/08 for Stress Form Zinc 1 tab daily per g-tube was on 1/10/08 at 8 am.	n. New nula w/	1/9/08 and ongoing	

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	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A BUILD	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY LETED C
		09G119		B, WING		01/	16/2008
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY	, STATE, ZIP CODE		
			4515 EDSC WASHING				
(X4) ID SIUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE	
1 500	Continued From pag	ge 15		1500	W .		1/16/08
	- Accuzyme ointme forearm and wrist to debride eschar an -Curasol gel to all healing. Review of Resident Summary dated Jan 2008 at approximate Resident #1 was addischarge diagnoses anemia, Bullous discharge diagnoses anemia, Bullous diagnoses anemia, Bullous discharge diagnoses anemia, Bullous discharge diagnoses anemia, Bullous di	ent to necrotic wound d healthy tissue to pro #1's hospital Dischar uary 7, 2008 on January 7, 2008 on January 8:12 AM. revealed mitted to the hospital with admitting diagn I UTI. Resident #1's son January 7, 2008 ease and alterations d nutrition. In an inte actical Nurse (LPN) approximately 10:00 hat the PCP had no orders with-in twenty ry 7, 2008, January 9 8. tented evidence that verbal telephone ord 24) hours.	rge uary 16, d that l on oses of included in erview on AM it ot signed y-four 0, 2008 the ers		3. The Accuzyme Ointme initiated on 1/16/08 as soon treatment arrived at the facilit nursing staff will ensure that the be no delay in the administra medication, treatment or service client. Also reference response to W 104.	as the ty. The ere will tion of to the	
	B. Resident #1 was on December 12, 200 of seizure disorder an (UTI). The resident v7, 2008 with diagnost Urinary Tract Infectio disease, and alteration the physicial Resident #1 received after his return from the following:	07 with admitting dia nd urinary tract infect was discharged on Jaces of seizure disorden (UTI), anemia, But ons in fluids, electroly an falled to ensure the appropriate quality of the contraction of the	gnoses tion anuary r, lous tes and tat		B. Reference response to W 32	2 a	2.28.08 ongoing
Ith Boardat	a) Interview with the LPN) on January 16,	Licensed Practical N 2008 at approximate	urse ely 8:50				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA VIBER:	A BUILDI	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING C C			
		09G119		B. WING 01/16/2008			
NAME OF F	ROVIDER OR SUPPLIER			= -	STATE, ZIP CODE	 1	
1DI 4515 EDS WASHING			4515 EDS WASHING	ON PLACE TON, DC	, NE 20019		•
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
I 500	Continued From pag AM revealed that the	- e Primary Care Phys	ician	1 500			
	(PCP) was the resid while he was hospits on January 13, 2008 the PCP came to the however, there was assessment.	ent's attending physialized. The LPN states of t	ician ed that scharge)				
					}		
						,	
				:			
	,						·
Irla Dan Iv				·			
คะเพลิกเลิย	on Administration						